

ADVANCING PERINATAL BEHAVIORAL HEALTHCARE IN NEVADA



ROSEMAN UNIVERSITY
OF HEALTH SCIENCES



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Disclaimer

The content is solely the responsibility of the authors and does not necessarily reflect the official views of the State of Nevada or the Substance Abuse and Mental Health Services Administration.

About the Study

This project examines the intersections between healthcare, behavioral health, child welfare, infant and early childhood systems in Nevada, identifying barriers to care that must be addressed to improve outcomes for perinatal women, their infants, and families.

Study period was April 2025 - September 2025

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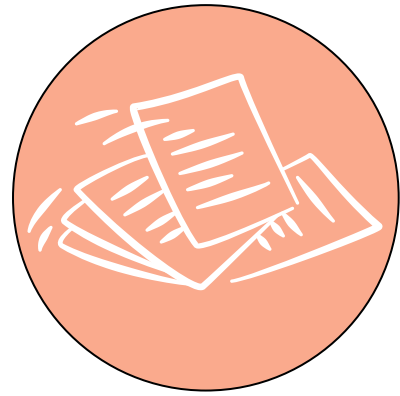
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Funded by the Nevada Department of Human Services, Division of Public and Behavioral Health and
operated by Roseman University of Health Sciences

Methodology

Literature Review



Reviewed 45 documents including policy documents, national/state reports and research papers on perinatal behavioral health.

Qualitative Interviews



Conducted qualitative interviews with healthcare providers, behavioral health practitioners, state agencies, payers, child welfare agencies, and women receiving treatment.

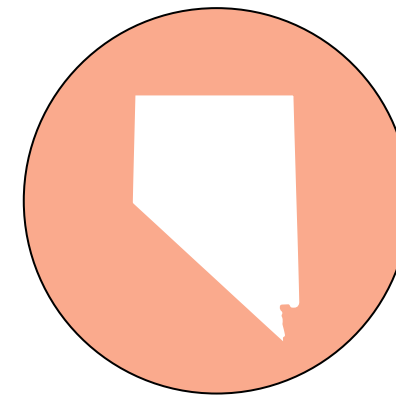
- Key Informant Interviews (24)
- Focus Group Discussions (7)

Qualitative Analysis



- Multi-level inductive coding
- Taguette for coding themes

Mapping



- Developed a geographic mapping of
 - Women's health and behavioral health services
 - CARA plan counts per birth at county level

Quotes from Participants

“We would love to screen, but we don't want to screen, not because it's not the right thing to do, but because we don't know who to do a warm handoff to, and not just a referral.”

“I didn't want to say anything, because I didn't want her (my baby) to get taken away. I thought about getting an abortion. I thought about what's going to happen, what's going on with my other three kids? It's scary. You don't want to tell somebody you're using drugs because you have a prior CPS.”

“Like I love when people ask me what the sustainability plan is, and I mean all you can really do is shrug your shoulders and say I hope that someone thinks this is important enough to give us maybe 20% of what we asked for within the general fund.”

“In Nevada, I feel helpless, no one knows how the system works. Hospitals have no incentive to for good quality, they get a bundled rate regardless. There is no quality control or enforcement without it, there is no real incentive for providers to screen; if anything they do not benefit from more work”

“Women also have a lot of stigma about reporting behavioral health symptoms and substance use. For many women, they don't feel comfortable disclosing because of fear of judgement or fear of CPS. It takes a lot of trust to get women to be honest.”

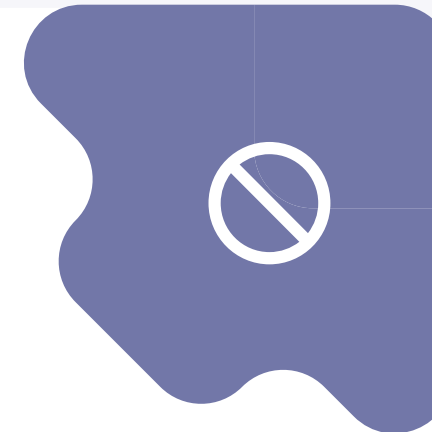
Key Findings



Unmet perinatal behavioral health needs in Nevada have contributed to **adverse outcomes for both mothers and their newborns.**

Adverse outcomes include exposure to substances in utero, developmental needs, child welfare involvement, and increased maternal morbidity and mortality related to overdose and suicide.

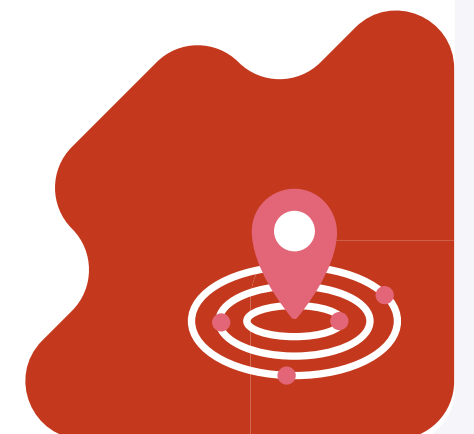
Several efforts, including the creation of **legislative policy and standards of care**, and allocation of funding exist to support the expansion of screening for mental health and substance use disorders during the perinatal period to identify pregnant and postpartum women in need of behavioral health care within medical settings.



Barriers to providing integrated and coordinated behavioral health screening and treatment **include lack of access to adequate prenatal care, challenges with reimbursement for integrated care models, stigma, and difficulties accessing specialty care for behavioral health.**

Specialty care for perinatal behavioral health care is limited and difficult to locate.

Care coordination across systems and payers presents complexities for providers with limited time and resources to support referrals.

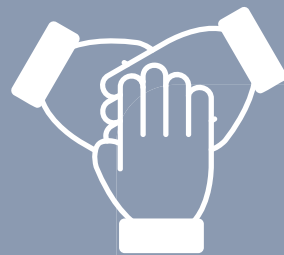


Key Findings



Challenges with navigating multiple systems with unclear eligibility requirements, including social services to address food insecurity, housing, transportation, and employment create additional barriers for pregnant and postpartum women and their families seeking care and resources.

Infant and early childhood systems, including pediatric healthcare, childcare, and developmental **services are fragmented and need a coordinated approach** to serving families in need of care across systems.

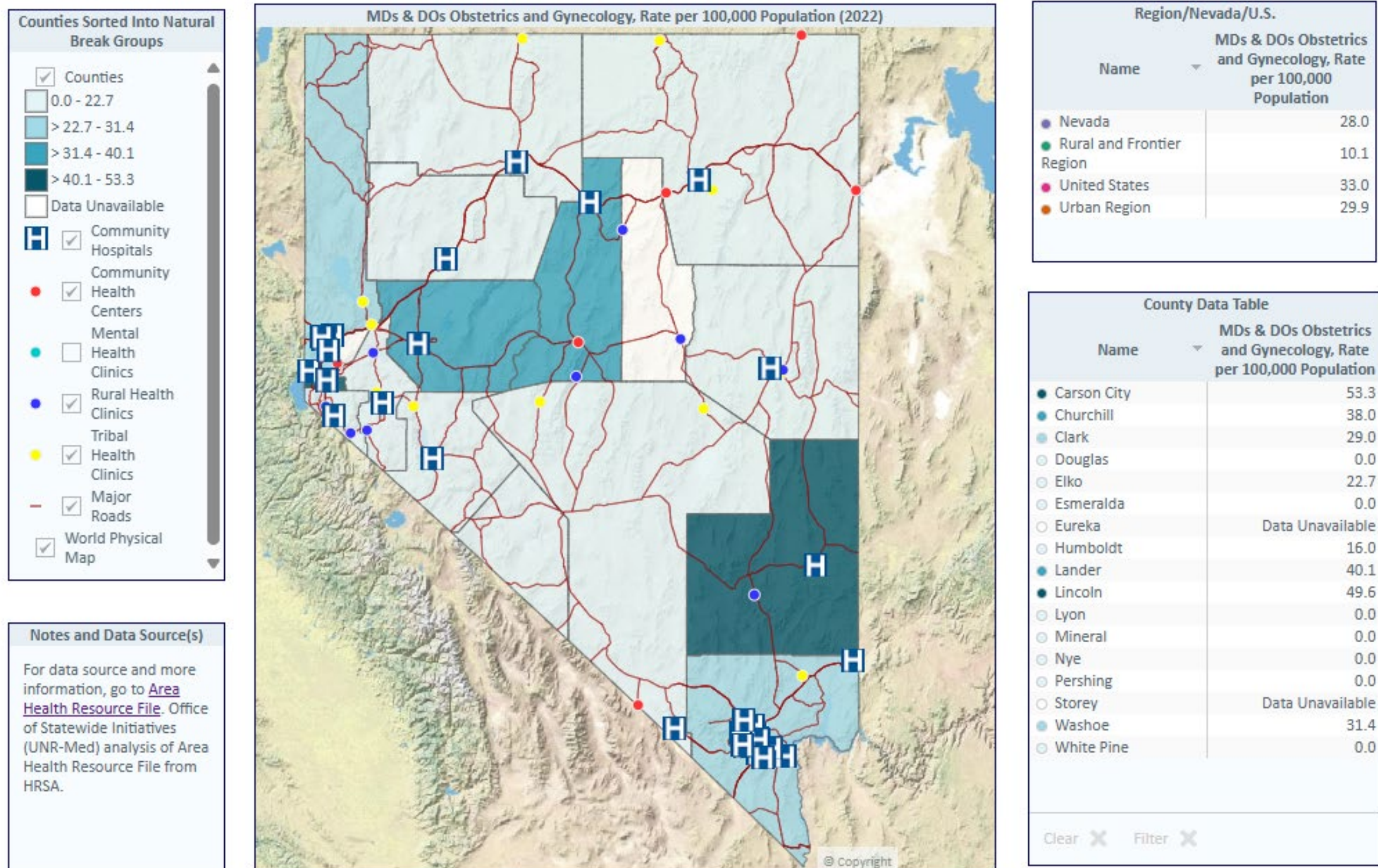


Child welfare systems lack the funding and resources to support prevention of child welfare involvement, family preservation, and family reunification, leading to high rates of child welfare involvement for families impacted by perinatal substance use.

Efforts to address sustainable financing, care quality and outcomes, and alignment of policies and best practices with standards of care must be coordinated across state agencies while local communities coordinate resources and services to support navigation for women and families in need of care.



OB/GYN Distribution



- Nevada's overall rate is 28.0 providers per 100,000 population falling below the national average of 33.0.
- Four counties are above the US average: Carson City (53.3), Churchill County (38.0), Lander (40.1), and Lincoln County (49.6),
- Rural and frontier regions average only 10.1 per 100,000, with seven counties (Douglas, Eureka, Lyon, Mineral, Nye, Pershing, and White Pine) reporting no providers at all.

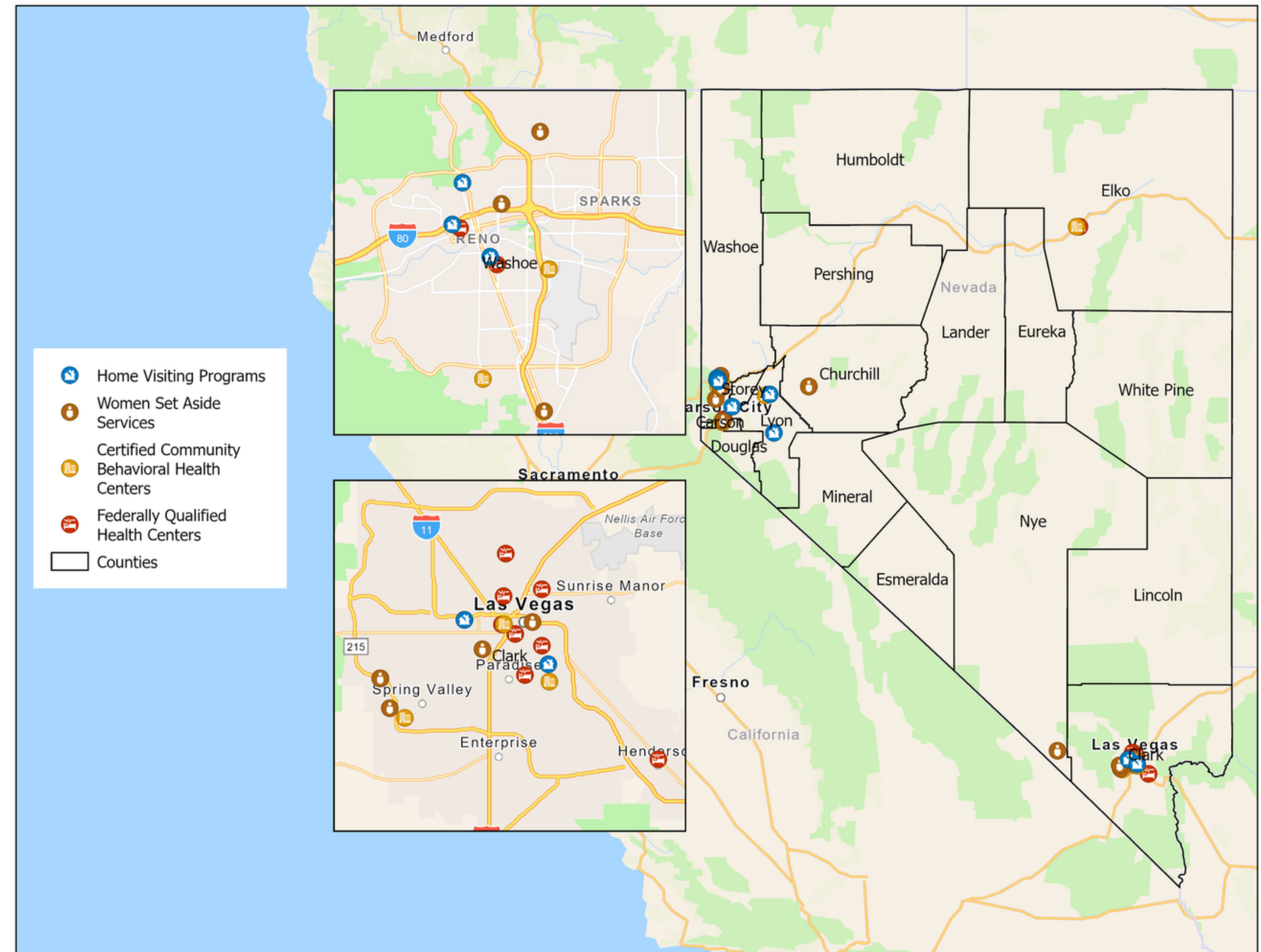
Source: Office of Statewide Initiatives, 2022

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Nevada's Perinatal Behavioral Health Network: Access and Geographic Gaps

In the state's largest population centers—Las Vegas, Reno, and Carson City, there is a high concentration of health facilities and recovery programs that are accessible to pregnant women.

But there are no dedicated perinatal behavioral health services, CCBHCs, or FQHCs in over half the state's counties (Douglas, Mineral, Esmeralda, Lincoln, Pershing, Humboldt, Eureka, Lander, and White Pine)



Source: Division of Public and Behavioral Health (DPBH) 2025

Recommendations

1

Develop a perinatal behavioral health strategic plan across state agencies within Department of Human Services and the Nevada Health Authority as part of the Children's Behavioral Health Transformation and connected to the Managed Care Quality Strategy.

2

Establish regional level perinatal behavioral health treatment networks to facilitate collaboration, communication, and resource sharing to support continuity of care and navigation to recovery support.

3

Increase access to high-quality, comprehensive, integrated perinatal behavioral health care across primary care, reproductive health, hospital, and pediatric settings.

4

Increase access and availability to coordinated specialty perinatal behavioral health services that are evidence-based, culturally responsive, trauma-informed, and focused on dyad centered care across the continuum of care.

5

Support families impacted by perinatal behavioral health issues to remain together and support infant and toddler development through connected early childhood systems.



PPC RECOMMENDATIONS

1.3

Connect perinatal behavioral health initiatives to existing behavioral health and child welfare innovation efforts to align measures, standards of care, incentives, accountability and oversight, data reporting, public health surveillance, health information exchange, and the selection and implementation of evidence-based practices.

1.4

Create and implement a strategic plan to oversee implementation, with a continuous quality improvement plan. Establish legislative priorities to support its implementation, including the allocation of funding to support programs and positions for sustainable action, establishing a Perinatal Quality Collaborative.

2.2

Promote standards of care and evidence-based practices to enhance the quality of care and care coordination (i.e., AIM Perinatal Behavioral Health Patient Safety Bundles).

2.4

Coordinate with state agencies and existing consortia/committees to ensure communication supports existing policies.

PPC RECOMMENDATIONS

3.1

Adopt the AIM Patient Safety Bundles as the standard of care guide for implementation of perinatal mental health and substance use disorders. (All levels)

3.2

Incentivize providers to screen for perinatal behavioral health and connect to follow-up care through alternative payment structures, such as rate enhancements or value-based contracting and the reduction of administrative burden. (Payers, Health Systems)

3.3

Create pathways to care to allow providers to quickly refer warm-hand-off and closed-loop referrals by establishing care coordination agreements and/or through contract requirements with managed care. (Providers, Payers, Health Systems)

3.4

Establish and sustain a Perinatal Access Line to connect providers with consultation support for psychiatry and addiction medicine. (Payers, State Agencies)

3.5

Promote integrated health and behavioral health care delivery models by aligning policy and reimbursement structures, removing barriers for enrollment and billing behavioral health services in medical settings. This includes ensuring managed care organizations have structures in place to reimburse a range of behavioral health integration models, including Collaborative Care Models. (Payers, State Agencies)

PPC RECOMMENDATIONS

3.6

Evaluate the universal bundled rate for pregnancy and post-partum care, as this policy has been identified as severely restricting access to community-based obstetric care and post-partum follow-up through providers, including FQHCs and Rural Health Clinics. (Payers, State Agencies, Providers, Health Systems)

3.7

Create a central repository for updated, reliable, high-quality information that providers can use to educate patients on perinatal behavioral health issues (both mental health and substance use) during pregnancy and the post-partum period. This information should include risks of substance use (including cannabis) during pregnancy and breastfeeding, treatment options and tools for shared decision making, resources for self-help, referrals to care and recovery supports. (Health Systems, State Agencies)

3.8

Enhance workforce competencies in perinatal behavioral health and integrated care delivery by infusing curriculum into pre-service behavioral health specialties and internships, medical and nursing education, residencies, and fellowships. (Payers, Health Systems, State Agencies)

3.9

Promote hospital-based, dyadic care using Eat, Sleep, Console for the management of Newborns with Neonatal Abstinence Syndrome. Evaluate the utilization of Neonatal Intensive Care Unit admissions for medical necessity for newborns for monitoring for withdrawal symptoms. Support improvement of care through quality and outcome measures through the Hospital Quality Collaborative to reduce unnecessary NICU admissions and the increased cost of care. (Payers, Health Systems, State Agencies)

4.6

Enhance workforce competencies through training in evidence-based practices and standards of care for the assessment, treatment, and recovery support to include level of care determinations, comprehensive treatment and family care planning, trauma-informed care, including Child Parent Psychotherapy and Reflective Supervision, and parenting support.
(Providers, Health Systems, Payers, State Agencies)

5.2

Establish a rapid review process for the Maternal Mortality Review Committee to ensure data and information are available as a public health surveillance tool to track causes of maternal mortality for actionable prevention solutions. Explore contracting with a public health agency or University to resolve the backlog of MMRC reviews from 2020 to date, ensuring data and information are available to inform recommendations on interventions and the development of quality and outcome initiatives

FULL DETAILED RECOMMENDATIONS FROM REPORT

DETAILED RECOMMENDATIONS

1.1

Establish a unified vision and goals for an interconnected system across state agencies, focusing on timely access to high-quality care and support for pregnant and post-partum women, recognizing that prenatal behavioral conditions qualify as high-risk pregnancies.

1.3

Connect perinatal behavioral health initiatives to existing behavioral health and child welfare innovation efforts to align measures, standards of care, incentives, accountability and oversight, data reporting, public health surveillance, health information exchange, and the selection and implementation of evidence-based practices.

1.2

Map existing programs, funding, authority, and policies across state agencies with touchpoints to systems and services that are part of the continuum for perinatal behavioral health.

1.4

Create and implement a strategic plan to oversee implementation, with a continuous quality improvement plan. Establish legislative priorities to support its implementation, including the allocation of funding to support programs and positions for sustainable action, establishing a Perinatal Quality Collaborative

2.1

Engage healthcare and behavioral health providers, social service agencies, child welfare agencies, hospitals, early intervention programs, health systems and payers across the five behavioral health regions in asset mapping, readiness assessment, and planning using an interconnected framework to establish the foundation of a local perinatal behavioral health treatment network.

2.3

Coordinate with state agencies and existing consortia/committees to ensure communication supports existing policies.

2.2

Promote standards of care and evidence-based practices to enhance the quality of care and care coordination (i.e., AIMPerinatal Behavioral Health Patient Safety Bundles).

2.4

Identify opportunities for capacity building through training and technical assistance and connect to existing resources at the regional, state, and national levels.

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Evaluate the universal bundled rate for pregnancy and post-partum care, as this policy has been identified as severely restricting access to community-based obstetric care and post-partum follow-up through providers, including FQHCs and Rural Health Clinics. (Payers, State Agencies, Providers, Health Systems)

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4.1

Evaluate the availability and adequacy of specialty mental health and SUD services across health care payer networks to include inpatient medication induction services, medically managed withdrawal management for pregnant women, residential treatment programs, transitional living options with recovery supports, outpatient treatment partial hospitalization programs, intensive outpatient treatment services. (Payers, State Agencies)

4.3

Provide adequate, sustainable funding through braided federal and state funding to ensure pregnant and post-partum women have immediate access to medically necessary care for substance use and co-occurring disorders, regardless of limitations of existing Medicaid benefits. (State Agencies)

4.2

Establish policies to prohibit state-funded or contracted specialty behavioral health providers, in non-hospital settings, from excluding caregivers with infants from accompanying them to care. (Payers, State Agencies)

4.4

Enact policies to promote access to opioid partial agonist medications for opioid use disorder (MOUD), including coverage for hospital-based induction, allowance of admission of individuals prescribed MOUD in state-funded and contracted substance use disorder providers and child welfare programs without restrictions. (Providers, Payers, State Agencies)

4.5 Adopt endorsements through the Nevada Association for Infant and Early Childhood Mental Health and the Perinatal Mental Health Certification Program through Postpartum Support International for providers and agencies who meet established criteria for providing specialty perinatal behavioral health services. (Health Systems, Payers, State Agencies)

4.7 Develop and adopt reimbursement rates for peer and family recovery support specialists, parenting coaches, community health workers, lactation consultants, and doulas at levels that recognize them as essential care team members in providing comprehensive family-centered care. (Payers, State Agencies)

4.6 Enhance workforce competencies through training in evidence-based practices and standards of care for the assessment, treatment, and recovery support to include level of care determinations, comprehensive treatment and family care planning, trauma-informed care, including Child Parent Psychotherapy and Reflective Supervision, and parenting support. (Providers, Health Systems, Payers, State Agencies)

5.1

Reevaluate regulations to guide the practice of Plans of Safe Care to divert families away from the child welfare system and direct them toward comprehensive support for infants and caregivers needing care. (Payers, State Agencies, Providers)

5.2

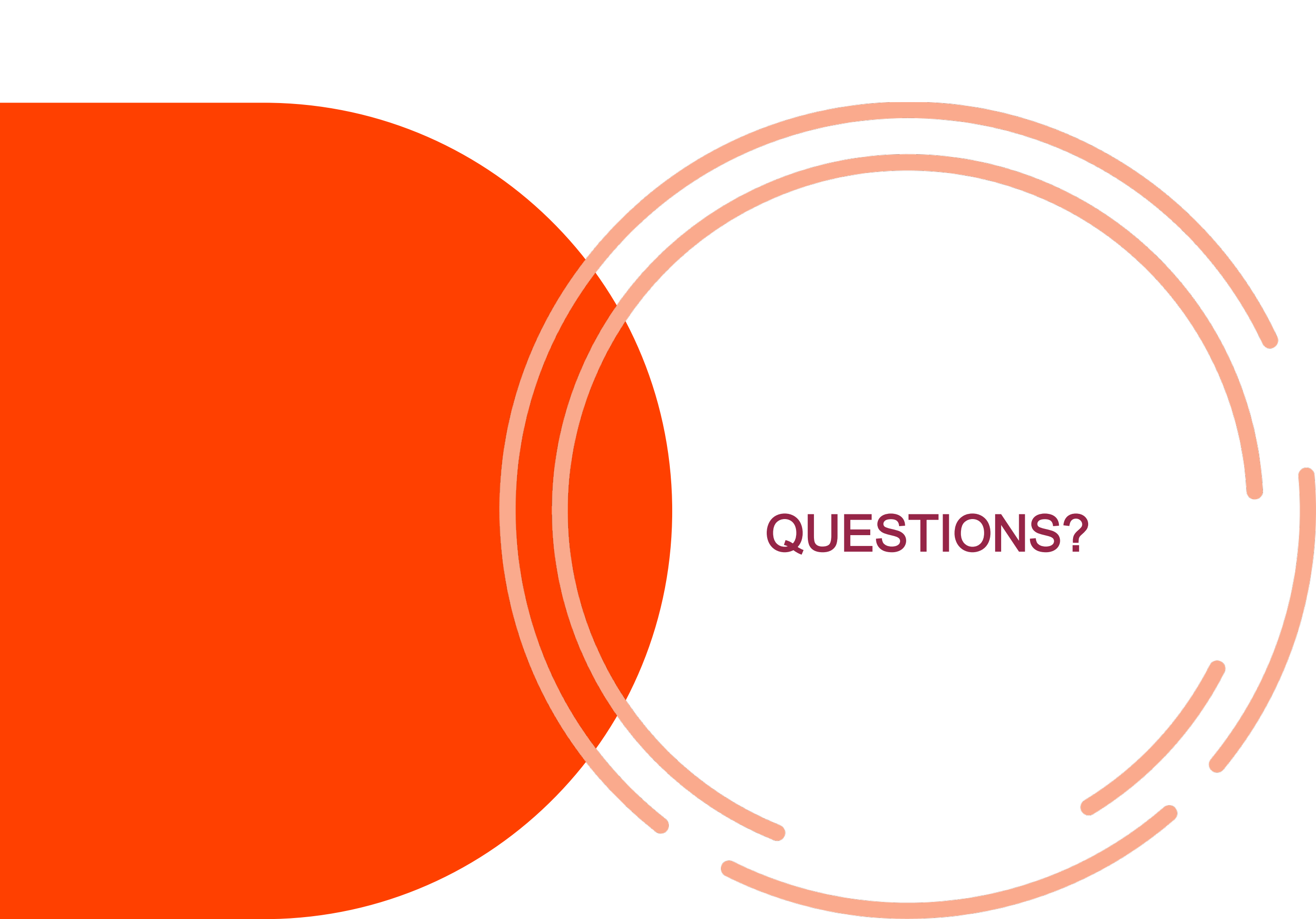
Establish a rapid review process for the Maternal Mortality Review Committee to ensure data and information are available as a public health surveillance tool to track causes of maternal mortality for actionable prevention solutions.

5.3

Coordinate efforts for programs to address social determinants of health, home visits, and early childhood services for infants, toddlers, and families to existing initiatives at the state and local levels. (State and Local Child Welfare Agencies)

5.4

Secure sustainable funding to expand access to Safe Babies Courts, NEIS, and Home-Visiting. Evaluate these and similar programs when formulating priorities for state agency budgets and the Children's Behavioral Health Transformation efforts, including the Specialty Managed Care Plan. (Providers, Payers, State and Local Agencies)



QUESTIONS?